August 25, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1303-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was 24 years of age at the time of the onset of low back pain reported with some lifting of a tire/wheel at work with ___ on ___. He had x-rays soon after, and also an MRI approximately three days after that. The MRI revealed no gross herniations, some disk shallow protrusions at a couple of levels, therefore fairly non-remarkable. The history and physical of 2/26/03 by ___ was reviewed. By that time, the patient had a course of some physical therapy and traction. The diagnostic impression listed was that of lumbar disc pain and myofascial pain. Further physical therapy, moderate medications and a home interferential muscle stimulator were recommended at that time. Two months later, a letter dated 4/29/03 requested the purchase of the stimulator unit.

REQUESTED SERVICE

The purchase of an interferential muscle stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

It does not appear that this unit is justified for purchase at this time. The natural course of this kind of injury and recovery in this young patient, without evidence of significant disc herniation, etc., would not justify the purchase of this unit. Rental of the unit early on for a period of one to three months would have been perhaps reasonable, but not beyond that length of time.

A good program of home exercises/lumbar rehab exercises as should be taught and emphasized with his patient would be the mainstay of his rehabilitation, long-term.Also, the recognized medical literature does not give any good evidence that this stimulator is "a good healing process" as noted in the letter dated 4/25/03. And the stimulator is not "necessary for his continued rehab," a statement noted in the same letter.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 25th day of August 2003.